| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155572 | A. BUILDING 00<br>B. WING | 02/08/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN HILLS HEALTH AND REHAB CENTER | 10352 N 600 E COUNTY LINE RD<br>DEMOTTE, IN 46310 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F0000 | | F0000 | | |

This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 12/20/11. This visit included the Post Survey Revisit (PSR) to the Investigation of Complaint IN00100554 completed on 12/20/11.

Complaint IN00100554-Not corrected.

Survey dates: February 6, 7, and 8, 2012

Facility number: 000471
Provider number: 155572
AIM number: 100290390

Survey team:
Kelly Sizemore, RN-TC
Regina Sanders, RN
(February 8, 2012)

Census bed type:
SNF/NF: 60
Residential: 13
Total: 73

Census payor type:
Medicare: 9
Medicaid: 38
Other: 26
Total: 73

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | Sample: 9<br>Residential: 3<br><br>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2<br><br>Quality review completed on February 15, 2012 by Bev Faulkner, RN | | | |

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| F0157 SS=D | A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. | | | |
| | Based on record review and interview, the facility failed to ensure residents' physicians were notified and notified timely of an inability to reinsert a urinary catheter and a low blood sugar for 2 of 9 residents reviewed for physician notification in a total sample of 9. | F0157 | **F157 The facility is requesting paper compliance for this deficiency.** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to | 02/21/2012 |

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| | (Residents #23 and #25)<br><br>Findings include:<br><br>1. Resident #23's record was reviewed on 02/08/12 at 11 a.m. The residents diagnoses included, but were not limited to, dementia and urinary retention.<br><br>An Admission/5-day Minimum Data Set (MDS) assessment, dated 12/16/11, indicated a brief interview for mental status should not be conducted because the resident was rarely/never understood and the resident had a short term memory problem with moderately impaired decision making skills (decisions poor; cues/supervision required). The MDS assessment indicated the resident had an indwelling urinary catheter.<br><br>A "Bowel and Bladder " evaluation, dated 12/23/11, indicated the resident had a urinary catheter for urinary retention.<br><br>A physicians order, dated 01/10/12, no time documented, indicated to change the indwelling urinary catheter, "tonight" and to obtain a urine specimen for a urinalysis.<br><br>The resident's Nurses' Notes indicated:<br><br>01/11/12 at 7:13 a.m., "attempted to | | continue to provide quality care. The facility does notify the physician and family with a change of condition. **1) Immediate actions taken for those residents identified: Physician was notified of inability of being able to reinsert the catheter, the resident was sent to the hospital when physician was notified of assessment and the catheter was replaced. Physician has been notified of low blood sugars. Resident has had no adverse effects. 2) How the facility identified other residents: 24 Hour Reports for the past 30 Days have been reviewed to identify any other residents that have had a change in condition and to verify that the physicians were notified of identified change. Diabetic resident's blood sugar results have been reviewed for the past 30 days to verify that the physicians were notified of results outside of parameters. 3) Measures put into place/ System changes: The Director of Nursing or designee will review the 24 Hour Reports a minimum of three times per week to identify any changes in condition and to verify that physicians have been notified of the change. Blood sugar results will be reviewed by the Director of Nursing or designee a minimum of three times per** | |

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| | change foley catheter unable to insert catheter will notify doctor." This was the first documentation to indicate an attempt was made to change the resident's urinary catheter.<br><br>01/11/12 at 1:14 p.m., "...Needs extensive assist of one staff for toileting...No complaints of pain or discomport (sic) at this time."<br><br>01/11/12 at 10:34 p.m., "resident denied any problems urinating all shift stated 'im [sic] peeing just fine,' writer gave resident a collection cup and asked him to urinate in it so it could be sent to lab for analysis. cna [sic] brought cup to nurse approx. (approximately) 10 minutes later and urine barely covered the bottom of the specimen cup. resident denied difficulty once again and refused to allow nurse to examine his abdomen...@ (at) approx 2130 (9:30 p.m.) and [sic] asked to palpate abdomen and resident consented. abdomen was rigid with no give over the bladder and resident flinched and said 'ouch.' he consented to allow writer to attempt to reinsert catheter. writer was unsuccessful. paged MD and called the answering service and received order to send to (hospital name) ER to have it reinserted..." (This was more than 12 hours since the nurse was unable to reinsert the catheter at 7:13 a.m.) | | **week to verify that physicians have been notified of any results outside of the ordered parameters. Licensed Nurses have been re-inserviced on timely notification of a resident when there is a change in condition or need to alter treatment and Physician Notification Policy. 4) How the corrective actions will be monitored: Director of Nursing or Designee will review the results of audits and present the data and report any patterns or trends identified to the Quality Assurance Committee monthly times three months and quarterly times one. Nurses that are identified as being non-compliant will be counseled. 5) Date of compliance: 2/21/12**<br>**F323 The facility is requesting paper compliance for this deficiency.** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does thoroughly investigate allegations of abuse and report to the Indiana State Department of Health according to the facility policy and state reporting guidelines. **1) Immediate actions taken for those residents identified:** | |

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| | 01/12/12 at 1:07 a.m., "resident being seen at (hospital name) for er [si]) evaluation and treatment at this time...resident continues to urinate small amounts of urine with abdomen hard and distended with c/o (complaints) pain/dicomfort [sic] previously on afternoon shift...MD aware of all above entrys [sic] at this time."<br><br>01/12/12 at 4:37 a.m., "resident returned from (hospital name)...catheter patent...denies any pain or discomfort...abdomen soft and non-distended..."<br><br>There was a lack of documentation to indicate the physician had been notified by the facility when the nurse was unable to reinsert the urinary catheter from 7:10 a.m. through 9:30 p.m.<br><br>The resident's urinary output record, dated 01/03/12 through 01/14/12, lacked documentation the resident had urine output on 01/11/12.<br><br>A, "Follow Up Question Report", received from the RN Nursing Consultant on 02/08/12 at 3:10 p.m., indicated on 01/11/12 at 1:59 p.m., 01/11/12 at 9:59 p.m., and 01/12/12 at 2:22 a.m. (resident still at hospital), the resident was | | **Resident was brought back inside the facility without injury. All door alarms were checked to ensure that they were properly functioning. A Mag-lock was applied to the door with an existing alarm. The resident was placed on the secured unit. 2) How the facility identified other residents: Elopement risk assessments were completed for all residents in the facility. Those that were identified as risk were already residing on the secured unit. 3) Measures put into place/ System changes: Facility Staff were re-inserviced on signs of elopement risk and responding to alarms. Elopement risk assessments will be completed on admission to identify those exhibiting behaviors that make them a risk for elopement. All residents will be re-screened for elopement risk at least quarterly and for a significant change in condition. Those residents identified to be at risk, will have measures put into place to prevent an elopement as defined by the state reporting guidelines. Residents who are observed as having new exit seeking behavior will be communicated to the charge nurse/Social Services for appropriate placement/intervention to** | |

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| | continent of urine. The form indicated, "...CONTINENT-complete control [included use of indwelling urinary catheter that does not leak urine]"<br><br>During an interview on 02/08/12 at 12:05 p.m., the Director of Nursing (DoN) indicated the physician had not been notified until 9:30 p.m., about the urinary catheter being unable to be reinserted. | | **prevent elopement. An Elopement assessment would be completed at that time. Door alarms/mag-lock and wander-guard system is present to alert staff of a cognitively impaired resident attempting to elope Rounds will be made by team leaders three times per week for 3 months then monthly, during rounds alarms on doors will be randomly set off and staff will be monitored for timely response. Management Staff have been in-serviced on Unusual Occurrence and Reporting Policy. 4) How the corrective actions will be monitored: Quality assurance rounds will be made as assigned by the Administrator daily to include random setting of alarms on various shifts and various doors to observe the timeliness of the response by the facility staff. Untimely response will be reported to the Administrator immediately for the appropriate action. The results of these audits will be reported monthly at the facility safety meeting for three months and then frequency will be determined by the members of the quality improvement team. The Administrator is responsible for the coordination and monitoring. 5) Date of compliance:** | |

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| | | | **2/17/12** | |

2. Resident #25's record was reviewed on 2/8/12 at 10:25 a.m. Resident #25's diagnoses included, but were not limited to, diabetes, emphysema, and hypertension.

Physician's orders, dated 12/17/11, indicated blood sugar three times a day, check physicians orders for sliding scale (amount of insulin given based on blood sugar result). Sliding scale is as follows: "0-59= 0 (no insulin) call physician..."

A January 2012 MAR (Medication Administration Record) indicated the resident's blood sugar at 7 a.m. on 1/15/12 was 54 and on 1/20/12 was 45.

The resident's record lacked documentation the physician was notified of the low blood sugars.

During an interview on 02/08/12 at 2:20 p.m., the RN Nursing Consultant indicated there was no documentation to indicate the resident's physician had been notified of the low blood sugars.

During an interview on 02/08/12 at 3:10 p.m., the DoN indicated she had contacted the resident's physician and physician's office and they were unable to recall if

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| | they had been notified of the low blood sugars.<br><br>A facility revised policy, dated 01/12, received from the DoN as current, and titled, "PHYSICIAN/FAMILY/RESPONSIBLE PARTY NOTIFICATION FOR CHANGE IN CONDITION" indicated, "To ensure that medical care problems are communicated to the attending physician in a timely, efficient, and effective manner...1. Physician Notification is to include, but is not limited to:...Change in condition that may warrant a change in current treatment...Blood glucose reading below 60...2. Physician Notification will be documented in the progress notes, it should contain information regarding the resident condition, physician notification, and any physician orders obtained."<br><br>This deficiency was cited on 12/20/11. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-5(a)(2)<br>3.1-5(a)(3) | | | |

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| F0225 SS=D | The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. | | | |
| | Based on observation, record review, and interview, the facility failed to thoroughly investigate and report to the Indiana State Department of Health, an unusual | F0225 | **F225 The facility is requesting paper compliance for this deficiency.** The filing of this plan of correction does not constitute an admission that the alleged | 02/21/2012 |

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| | occurrence related to a resident exiting the building unattended for 1 of 3 residents who were at risk for elopement in a sample of 9. (Resident #7)<br><br>Findings include:<br><br>Resident #7's record was reviewed on 2/7/12 at 2:30 p.m. Resident #7's diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety, and Alzheimer's disease.<br><br>Resident #7 was observed, on 2/7/12 at 3:21 p.m., on the locked Alzheimer's Unit sitting in a chair attending an activity. She had a sensor alarm and wanderguard on.<br><br>A quarterly MDS (Minimum Data Set), dated 10/25/11, indicated the resident had short and long term memory loss and was severely impaired for daily decision making.<br><br>An Elopement Risk Assessment, dated 11/14/11, indicated the resident had the ability to move about the facility independently, a diagnosis of Alzheimer's disease, poor judgement/impaired safety awareness, and a history of wandering. It indicated the resident "has a Wanderguard bracelet in place." | | deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does thoroughly investigate allegations of abuse and report to the Indiana State Department of Health according to the facility policy and state reporting guidelines. **1) Immediate actions taken for those residents identified: Resident was brought back inside the facility without injury. All door alarms were checked to ensure that they were properly functioning. A mag-lock was applied to the door with an existing alarm. The resident was placed on the secured unit. 2) How the facility identified other residents: Elopement risk assessments were completed for all residents in the facility. Those that were identified as risk are already residing on the secured unit. 3) Measures put into place/ System changes: Facility Staff were re-inserviced on signs of elopement risk and responding to alarms. Elopement risk assessments will be completed on admission to identify those exhibiting behaviors that make them a risk for elopement. All residents will be re-screened for elopement risk at least quarterly and for a significant** | |

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| | A Social Service note, dated 1/12/12 at 12:49 p.m., indicated "Resident was moved to the ACU (locked Alzheimer's Unit) yesterday due to her exiting out of door. Resident was easily redirected back into the facility. Family ws [sic] in agreement with move..." The resident's record lacked any other documentation regarding the resident exiting the building.<br><br>An Internal Investigation form, dated 1/11/12 at 11:35 a.m., indicated "Description of Occurrence: The resident exited the facility through the double set of doors on the Assisted Living unit by the pool room. She was returned to the facility without injury...Relative to this occurrence the following statement was provided: She (LPN #1) stated that she saw Resident #7 rolling down the incline of the inner parking lot. She (LPN #1) stated that she was on the North Hall looking out the exit door. She (LPN #1) exited the facility promptly and assessed the resident for injuries and assisted her back into the facility. She (LPN #1) stated that the resident did not have any injuries."<br><br>An Occurrence Management Log for January 2012 lacked the elopement on 1/11/12. | | **change in condition. Those residents identified to be at risk, will have measures put into place to prevent an elopement as defined by the state reporting guidelines. Residents who are observed as having new exit seeking behavior will be communicated to the charge nurse/Social Services for appropriate placement/intervention to prevent elopement. An Elopement assessment would be completed at that time. Door alarms/mag-lock and wander-guard system is present to alert staff of a cognitively impaired resident attempting to elope Rounds will be made by team leaders three times per week for 3 months then monthly, during rounds alarms on doors will be randomly set off and staff will be monitored for timely response. Management Staff have been in-serviced on Unusual Occurrence and Reporting Policy. 4) How the corrective actions will be monitored: Quality assurance rounds will be made as assigned by the Administrator daily to include random setting of alarms on various shifts and various doors to observe the timeliness of the response by the facility staff. Untimely response will be reported to** | |

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|---|---|---|---|
| | 155572 | A. BUILDING 00<br>B. WING | 02/08/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN HILLS HEALTH AND REHAB CENTER | 10352 N 600 E COUNTY LINE RD<br>DEMOTTE, IN 46310 |

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| | During an interview with the DoN (Director of Nursing), on 2/7/12 at 4:10 p.m., she indicated Resident #7 exited the facility on 1/11/12 and it was not reported. She indicated the previous Administrator was tracking all unusual occurrences and it was not on the reportable log.<br><br>During an interview with the DoN, on 2/7/12 at 4:30 p.m., she indicated Resident #7's "whereabouts were known." She indicated she talked with LPN #1 and LPN #1 indicated she saw the door opening and saw Resident #7 come out and she went to get her. LPN #1 indicated Resident #7 went out of the door on the Assisted Living hall and she (the nurse) was on the North Hall.<br><br>During an interview with LPN #1, on 2/8/12 at 9:20 a.m., she indicated she was on the hall (hall by the main dining room) going to the West hall. She indicated she saw Resident #7 come down the incline in her wheelchair and was "rolling across the parking lot." She indicated she did not hear the alarm going off. She indicated she went out and got the resident and brought her back in. "I reported it to her nurse, I was not her nurse that day." She indicated Resident #7 did have a wanderguard on. | | **the Administrator immediately for the appropriate action. The results of these audits will be reported monthly at the facility safety meeting for three months and then quarterly for a total of 6 months. The Administrator is responsible for the coordination and monitoring. 5) Date of compliance: 2/21/12** | |

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| | Review of the Internal Investigation of 1/11/12, indicated three Residential Residents were interviewed and 2 of the 3 Residential Residents heard a door alarm sound. The Housekeeping Supervisor indicated she was returning from break and saw Resident #7 rolling down the sidewalk from the apartment side of the building. The Internal Investigation lacked interviews from other staff members to indicate if they heard the alarm and why it was not responded to.<br><br>During an interview with the DoN, on 2/8/12 at 8:50 a.m., she indicated the policy was revised in January 2012. She indicated the policy was copied right from the state regulations. She indicated the Regional Consultant said it was not reported because of the policy change.<br><br>A facility policy titled "Administratiave [sic] Accidents and Incidents Investigating and Reporting," dated 1/2012 and received as current from the DoN on 2/8/12 at 9:25 a.m., indicated "Purpose: To ensure that reportable occurrences are recorded and monitored to facilitate compliance with the state and federal laws. Policy: Unusual Occurrences reported to the Indiana State Department of Health will be recorded, tracked, and monitored to insure residents are receiving appropriate care and | | | |

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| | services...Policy Interpretation and Implementation: Occurrences to be reported: Facilities are required by law to report unusual occurrences within 24 hours of occurrence...7. Resident Elopement A. A cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown..."<br><br>3.1-28(d) | | | |

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| F0226 SS=D | The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. | | | |
| | Based on record review and interview, the facility failed to follow the facility's policy for investigating and reporting to the Indiana State Department of Health (ISDH), an unusual occurrence related to an elopement for 1 of 3 residents at risk for elopement in a sample of 9 residents. (Resident #7)<br><br>Findings include:<br><br>Resident #7's record was reviewed on 2/7/12 at 2:30 p.m. Resident #7's diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety, and Alzheimer's disease.<br><br>A quarterly MDS (Minimum Data Set), dated 10/25/11, indicated the resident had short and long term memory loss and was severely impaired for daily decision making.<br><br>An Elopement Risk Assessment, dated 11/14/11, indicated the resident had the ability to move about the facility independently, a diagnosis of Alzheimer's disease, poor judgement/impaired safety awareness, and a history of wandering. It indicated the resident "has a Wanderguard | F0226 | **F226 The facility is requesting paper compliance for this deficiency.** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does thoroughly investigate allegations of abuse and report to the Indiana State Department of Health according to the facility policy and state reporting guidelines. **1) Immediate actions taken for those residents identified: Resident was brought back inside the facility, no injury or emotional distress were noted. All door alarms were checked to ensure that they were properly functioning. Mag-lock was added to the door in the Assisted Living in addition to the existing alarm. Key pads added to doors that were not equipped with wander-guard system. Resident was transferred to the secured Alzheimer's Unit. 2) How the facility identified other residents: Elopement risk assessments were completed for all residents in the facility.** | 02/21/2012 |

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| | bracelet in place."<br><br>A Social Service note, dated 1/12/12 at 12:49 p.m., indicated "Resident was moved to the ACU (locked Alzheimer's Unit) yesterday due to her exiting out of door. Resident was easily redirected back into the facility. Family ws (sic) in agreement with move..." The resident's record lacked any other documentation regarding the resident exiting the building."<br><br>An Internal Investigation form, dated 1/11/12 at 11:35 a.m., indicated "Description of Occurrence: The resident exited the facility through the double set of doors on the Assisted Living unit by the pool room. She was returned to the facility without injury...Relative to this occurrence the following statement was provided: She (LPN #1) stated that she saw Resident #7 rolling down the incline of the inner parking lot. She (LPN #1) stated that she was on the North Hall looking out the exit door. She (LPN #1) exited the facility promptly and assessed the resident for injuries and assisted her back into the facility. She (LPN #1) stated that the resident did not have any injuries.<br><br>An Occurrence Management Log for January 2012 lacked the elopement on | | **Those that were identified as risk have had wander guard bracelets applied or are already residing on the secured unit. 24 Hour Reports for the past 30 days have been reviewed to identify any unusual occurrences. None were identified. 3) Measures put into place/ System changes: Documentation will be reviewed during morning meetings a minimum of three times per week to identify any exit seeking behaviors. Those identified will have a new elopement risk assessment completed and wander guard bracelets applied. Elopement risk assessments will be done quarterly and with significant changes. Twenty four hour reports will be reviewed by the Director of Nursing or designee during morning meetings to identify any unusual occurrences. Administrator or designee will ensure that a thorough investigation will be conducted for any unusual occurrences identified. Administrator or designee will audit each unusual occurrence to ensure that a complete and thorough investigation has been completed and that appropriate entities have been notified. Rounds will be made by team leaders three times per week** | |

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| | 1/11/12.<br><br>During an interview with the DoN (Director of Nursing), on 2/7/12 at 4:10 p.m., she indicated Resident #7 exited the facility on 1/11/12 and it was not reported. She indicated the previous Administrator was tracking all unusual occurrences and it was not on the reportable log.<br><br>During an interview with the DoN, on 2/7/12 at 4:30 p.m., she indicated Resident #7's "whereabouts were known." She indicated she talked with LPN #1 and LPN #1 indicated she saw the door opening and saw Resident #7 come out and she went to get her. LPN #1 indicated Resident #7 went out of the door on Assisted Living hall and she (the nurse) was on the North Hall.<br><br>During an interview with LPN #1, on 2/8/12 at 9:20 a.m., she indicated she was on the hall (hall by the main dining room) going to the West hall. She indicated she saw Resident #7 come down the incline in her wheelchair and was "rolling across the parking lot." She indicated she did not hear the alarm going off. She indicated she went out and got the resident and brought her back in. "I reported it to her nurse, I was not her nurse that day." She indicated Resident #7 did have a | | **for 3 months then monthly, during rounds alarms on doors will be randomly set off and staff will be monitored for timely response. All staff has been in-serviced on observing for behaviors that might put residents at risk for elopement such as exit seeking. Also, staff will report immediately any of those behaviors to the DON/Administrator. Management Staff have been in-serviced on Unusual Occurrence and Reporting Policy. 4) How the corrective actions will be monitored: Administrator or designee will report any patterns or trends identified to the Quality Assurance Committee monthly times three months and quarterly times one. Administrator or designee will report the results of audits of unusual occurrences and any patterns or trends that have been identified to the Quality Assurance Committee monthly for three months then quarterly time's one. 5) Date of compliance: 2/21/12** | |

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| | wanderguard on.<br><br>Review of the Internal Investigation of 1/11/12, indicated three Residential Residents were interviewed and 2 of the 3 Residential Residents heard a door alarm sound. The Housekeeping Supervisor indicated she was returning from break and saw Resident #7 rolling down the sidewalk from the apartment side of the building. The investigation lacked interviews from other staff members to indicate if they heard the alarm and why it was not responded to.<br><br>During an interview on 2/08/12 at 3:10 p.m., the Regional Consultant indicated per interview with the Administrator at the time of the occurrence, the staff did not hear the alarm, they were in the dining room and the nurse was working the other side of the building. She indicated the staff did respond because they went out and got her.<br><br>During an interview with the DoN, on 2/8/12 at 8:50 a.m., she indicated the policy was revised in January 2012. She indicated the policy was copied right from the state regulations. She indicated the Regional Consultant said it was not reported because of the policy change.<br><br>A facility policy titled "Administratiave | | | |

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| | (sic) Accidents and Incidents Investigating and Reporting," dated 1/2012 and received as current from the DoN, on 2/8/12 at 9:25 a.m., indicated "Purpose: To ensure that reportable occurrences are recorded and monitored to facilitate compliance with the state and federal laws. Policy: Unusual Occurrences reported to the Indiana State Department of Health will be recorded, tracked, and monitored to insure residents are receiving appropriate care and services...Policy Interpretation and Implementation: Occurrences to be reported: Facilities are required by law to report unusual occurrences within 24 hours of occurrence...7. Resident Elopement A. A cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown..."<br><br>3.1-38(a) | | | |

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| F0309 SS=D | Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | | | |
| | Based on record review and interview, the facility failed to monitor for urinary output and assess a resident's abdomen/bladder after they were unable to reinsert a urinary catheter in a resident with a diagnosis of urinary retention for 1 of 9 residents reviewed for necessary care and services in a total sample of 9. (Resident #23)<br><br>Findings include:<br><br>Resident #23's record was reviewed on 02/08/12 at 11 a.m. The residents diagnoses included, but were not limited to, dementia and urinary retention.<br><br>An Admission/5-day Minimum Data Set (MDS) assessment, dated 12/16/11, indicated a brief interview for mental status should not be conducted because the resident was rarely/never understood and the resident had a short term memory problem with moderately impaired decision making skills (decisions poor; cues/supervision required). The MDS assessment indicated the resident had an indwelling urinary catheter. | F0309 | **F309 The facility is requesting paper compliance for this deficiency.** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does provide services to attain and maintain the highest level of functioning. **1) Immediate actions taken for those residents identified: Physician was notified of inability of being able to reinsert the catheter, was sent to the hospital when physician was notified of assessment and the catheter was replaced. The catheter was reinserted at the hospital and the resident returned to the facility. 2) How the facility identified other residents: 24 Hour Reports for the past 30 Days have been reviewed to identify any other residents that have had a change in condition and to verify that the physicians were notified of identified change. 3) Measures put into place/ System changes: 24 Hour** | 02/21/2012 |

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| | A "Bowel and Bladder" evaluation, dated 12/23/11, indicated the resident had a urinary catheter for urinary retention.<br><br>A physician's order, dated 01/10/12, no time documented, indicated to change the indwelling urinary catheter, "tonight" and to obtain a urine specimen for a urinalysis.<br><br>The resident's Nurses' Notes indicated:<br><br>01/11/12 at 7:13 a.m., "attempted to change foley catheter unable to insert catheter will notify doctor". This was the first documentation to indicate an attempt was made to change the resident's urinary catheter.<br><br>01/11/12 at 1:14 p.m., "...Needs extensive assist of one staff for toileting...No complaints of pain or discomport [sic] at this time."<br><br>01/11/12 at 10:34 p.m., "resident denied any problems urinating all shift stated 'im [sic] peeing just fine' writer gave resident a collection cup and asked him to urinate in it so it could be sent to lab for analysis. cna [sic] brought cup to nurse approx. (approximately) 10 minutes later and urine barely covered the bottom of the specimen cup. resident denied difficulty | | **Reports will be reviewed by the Director of Nursing or designee a minimum of three times per week to identify any changes in condition and to verify that physicians have been notified of the change. Licensed Nurses have been in-serviced on Physician Notification Protocol, Urine Output and abdomen/bladder assessment for residents with urinary retention. 4) How the corrective actions will be monitored: Director of Nursing or Designee will review the results of audits and present the data and report any patterns or trends identified to the Quality Assurance Committee monthly times three months and quarterly times one. Nurses that are identified as being non-compliant will be counseled. 5) Date of compliance: 2/21/12** | |

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| | once again and refused to allow nurse to examine his abdomen...@ (at) approx 2130 (9:30 p.m.) and [sic] asked to palpate abdomen and resident consented. abdomen was rigid with no give over the bladder and resident flinched and said ouch. he consented to allow writer to attempt to reinsert catheter. writer was unsuccessful. paged MD and called the answering service and received order to send to (hospital name) ER to have it reinserted..." (This was more than 12 hours since the nurse was unable to reinsert the catheter at 7:13 a.m.)<br><br>01/12/12 at 1:07 a.m., "resident being seen at (hospital name) for er [sic] evaluation and treatment at this time...resident continues to urinate small amounts of urine with abdomen hard and distended with c/o (complaints) pain/dicomfort [sic] previously on afternoon shift...MD aware of all above entrys [sic] at this time." (This was 18 hours after the facility could not reinsert the urinary catheter)<br><br>01/12/12 at 4:37 a.m., "resident returned from (hospital name)...catheter patent...denies any pain or discomfort...abdomen soft and non-distended..."<br><br>There was a lack of documentation to | | | |

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| | indicate the physician had been notified by the facility when the nurse was unable to reinsert the urinary catheter from 7:10 a.m. through 9:30 p.m.<br><br>There was a lack of documentation the resident had been assessed for urinary output and condition of the abdomen from 7:13 a.m. through 9:30 p.m.<br><br>The resident's urinary output record, dated 01/03/12 through 01/14/12, lacked documentation the resident had urine output on 01/11/12.<br><br>During an interview on 02/08/12 at 3:10 p.m., the RN Nursing Consultant indicated if the resident did not have a catheter, urinary output would not have been recorded and the staff would have only marked if the resident was continent or not.<br><br>A, "Follow Up Question Report," received from the RN Nursing Consultant on 02/08/12 at 3:10 p.m., indicated on 01/11/12 at 1:59 p.m., 01/11/12 at 9:59 p.m., and 01/12/12 at 2:22 a.m. (resident still at hospital), the resident was continent of urine. The form indicated, "...CONTINENT-complete control [included use of indwelling urinary catheter that does not leak urine]" The form lacked documentation of the amount | | | |

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| | of urine the resident had.<br><br>During an interview on 02/08/12 at 12:05 p.m., the Director of Nursing (DoN) indicated the physician had not been notified until 9:30 p.m., about the urinary catheter being unable to be reinserted. She indicated there was no documentation in the Nurses' Notes to indicate the resident had voided. She indicated no one had attempted to reinsert the urinary catheter until 9:30 that evening. She indicated she would, "expect" to see documentation of monitoring the resident.<br><br>This deficiency was cited on 12/20/11. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-37(a) | | | |

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| F0323 SS=D | The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | F0323 | **F323 The facility is requesting paper compliance for this deficiency.** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does thoroughly investigate allegations of abuse and report to the Indiana State Department of Health according to the facility policy and state reporting guidelines. **1) Immediate actions taken for those residents identified: Resident was brought back inside the facility without injury. All door alarms were checked to ensure that they were properly functioning. A Mag-lock was applied to the door with an existing alarm. The resident was placed on the secured unit. 2) How the facility identified other residents: Elopement risk assessments were completed for all residents in the facility. Those that were identified as risk were already residing on the secured unit. 3) Measures put into place/ System changes: Facility Staff were** | 02/21/2012 |

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| | | | **re-inserviced on signs of elopement risk and responding to alarms. Elopement risk assessments will be completed on admission to identify those exhibiting behaviors that make them a risk for elopement. All residents will be re-screened for elopement risk at least quarterly and for a significant change in condition. Those residents identified to be at risk, will have measures put into place to prevent an elopement as defined by the state reporting guidelines. Residents who are observed as having new exit seeking behavior will be communicated to the charge nurse/Social Services for appropriate placement/intervention to prevent elopement. An Elopement assessment would be completed at that time. Door alarms/mag-lock and wander-guard system is present to alert staff of a cognitively impaired resident attempting to elope Rounds will be made by team leaders three times per week for 3 months then monthly, during rounds alarms on doors will be randomly set off and staff will be monitored for timely response. Management Staff have been in-serviced on Unusual Occurrence and Reporting Policy. 4) How the** | |

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| | | | **corrective actions will be monitored: Quality assurance rounds will be made as assigned by the Administrator daily to include random setting of alarms on various shifts and various doors to observe the timeliness of the response by the facility staff. Untimely response will be reported to the Administrator immediately for the appropriate action. The results of these audits will be reported monthly at the facility safety meeting for 3 months, then quarterly for a total of 6 months. The Administrator is responsible for the coordination and monitoring.**<br>**5) Date of compliance: 2/17/12** | |
| | Based on record review and interview, the facility failed to ensure a resident received adequate supervision related to a resident exiting the building unattended for 1 of 3 residents reviewed at risk for elopement, in a sample of 9. (Resident #7)<br><br>Findings include:<br><br>Resident #7's record was reviewed on 2/7/12 at 2:30 p.m. Resident #7's diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety, and Alzheimer's disease.<br><br>A quarterly MDS (Minimum Data Set) | | | |

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| | assessment, dated 10/25/11, indicated the resident had short and long term memory loss and was severely impaired for daily decision making.<br><br>An Elopement Risk Assessment, dated 11/14/11, indicated the resident had the ability to move about the facility independently, a diagnosis of Alzheimer's disease, poor judgement/impaired safety awareness, and a history of wandering. It indicated the resident "has a Wanderguard bracelet in place."<br><br>A care plan, "Resident exhibits wandering with the potential for exit seeking behaviors," dated 4/10/11 and revised 11/7/11, indicated wanderguard in place.<br><br>A Social Service note, dated 1/12/12 at 12:49 p.m., indicated "Resident was moved to the ACU (locked Alzheimer's Unit) yesterday due to her exiting out of door. Resident was easily redirected back into the facility. Family ws [sic] in agreement with move..." The resident's record lacked any other documentation regarding the resident exiting the building.<br><br>An Internal Investigation form, dated 1/11/12 at 11:35 a.m., indicated "Description of Occurrence: The resident exited the facility through the double set | | | |

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| | of doors on the Assisted Living unit by the pool room. She was returned to the facility without injury...Relative to this occurrence the following statement was provided: (LPN #1) stated that she saw (Resident #7) rolling down the incline of the inner parking lot. She (LPN #1) stated that she was on the North Hall looking out the exit door. She (LPN #1) exited the facility promptly and assessed the resident for injuries and assisted her back into the facility. She (LPN #1) stated that the resident did not have any injuries.<br><br>During an interview with the DoN, on 2/7/12 at 4:30 p.m., she indicated Resident #7's "whereabouts were known." She indicated she talked with LPN #1 and LPN #1 indicated she saw the door opening and saw Resident #7 come out and she went to get her. LPN #1 indicated Resident #7 went out of the door on the Assisted Living hall and she (the nurse) was on the North Hall.<br><br>During an interview with LPN #1, on 2/8/12 at 9:20 a.m., she indicated she was on the hall (hall by the main dining room) going to the West hall. She indicated she saw Resident #7 come down the incline in her wheelchair and was "rolling across the parking lot." She indicated she did not hear the alarm going off. She indicated | | | |

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| | she went out and got the resident and brought her back in. "I reported it to her nurse, I was not her nurse that day." She indicated Resident #7 did have a wanderguard on.<br><br>During an observation on 2/8/12 at 9:35 with LPN #1, she indicated the door she saw the resident through was the glass door past the Maintenance Office on the right. She indicated the Assisted Living door was not visible from where she was. She indicated she did not see Resident #7 come out the door.<br><br>During an observation, on 2/8/12 at 9:45 a.m., a key pad lock was noted by the door at the end of the Assisted Living door.<br><br>During an interview with the DoN, on 2/8/12 at 9:50 a.m., she indicated the Assisted Living door had an alarm at the time of the elopement. She indicated the alarm would go off if anybody went out the door. She indicated Resident #7 never tried to get out of the doors before. She indicated the resident's family was notified and were in agreement to move the resident to the ACU.<br><br>Review of the Internal Investigation of 1/11/12 indicated three Residential Residents were interviewed and 2 of the 3 | | | |

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| | Residential Residents heard the door alarm sound. The Housekeeping Supervisor indicated she was returning from break and saw Resident #7 rolling down the sidewalk from the apartment side of the building. The internal investigation lacked interviews from other staff members to indicate if they heard the alarm and why it was not responded to.<br><br>During an interview on 2/08/12 at 3:10 p.m., the Regional Consultant indicated per interview with the Administrator at the time of the occurrence, the staff did not hear the alarm, they were in the dining room and the nurse was working the other side of the building. She indicated the staff did respond because they went out and got her.<br><br>This deficiency was cited on 12/20/11. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>This F tag relates to Complaint: IN00100554.<br><br>3.1-45(a)(2) | | | |